DEPARTMENT OF SOCIAL AND HEALTH SERVICES
HEALTH AND RECOVERY SERVICES ADMINISTRATION
Olympia, Washington

To: School Districts
Educational Service Districts
Washington State School for the Blind
Washington State School for the Deaf
Managed Care Organizations

From: Douglas Porter, Assistant Secretary
Health and Recovery Services
Administration (HRSA)

Memorandum No.: 07-69
Issued: November 28, 2007

For information, contact
800.562.3022 or go to:
http://maa.dshs.wa.gov/contact/prucontact.asp

Subject: School Medical Services: Updates to Payment Method, Procedure Codes, and Provider Qualifications

Retroactive to dates of service on and after September 1, 2007, the Department of Social and Health Services (DSHS) has updated the payment method, covered services, and provider qualifications for school medical services provided to special education students enrolled in Title XIX Medicaid.

Payment Method Updates

On September 1, 2007, DSHS began paying school districts directly for the services provided to Medicaid clients instead of sending payment to the Office of the Superintendent of Public Instruction (OSPI). The checks and the remittance and status reports are now sent directly to the school district main office in care of the business manager. The school district business manager is responsible for sharing program information with other school district employees.

Retroactive to dates of service on and after September 1, 2007, the payment method for services has changed.

Before September 1, 2007	On and after September 1, 2007
DSHS used a cost-based payment method.	DSHS pays school districts using the Resource-Based Relative Value Scale (RBRVS) payment method. Providers must use an expanded set of procedure codes to bill DSHS for services provided.

Procedure Code Updates

Providers must use the following procedure codes when billing DSHS for services provided to special education students enrolled in Title XIX Medicaid.

Physical Therapy Services

Procedure Code	Modifier	Brief Description
97001		PT evaluation
97002		PT reevaluation
97110		Therapeutic exercises
97112		Neuromuscular reeducation
97116		Gait training therapy
97124		Massage therapy
97139		Physical medicine procedure
97150		Group therapeutic procedures
97530		Therapeutic activities
97535		Self care mngment training
97537		Community/work reintegration
97542		Wheelchair mngment training
97750		Physical performance test
97755		Assistive technology assess
97760		Orthotic mgmt and training
97761		Prosthetic training
97762		C/o for orthotic/prosth use

Occupational Therapy Services

Procedure Code	Modifier	Brief Description
95851		Range of motion measurements
95852		Range of motion measurements
97003		Ot evaluation
97004		Ot re-evaluation
97110		Therapeutic exercises
97112		Neuromuscular reeducation
97150		Group therapeutic procedures
97530		Therapeutic activities
97532		Cognitive skills development
97533		Sensory integration
97535		Self care mngment training
97537		Community/work reintegration
97542		Wheelchair mngment training

Occupational Therapy Services (cont.)

Procedure Code	Modifier	Brief Description
97750		Physical performance test
97755		Assistive technology assess
97760		Orthotic mgmt and training
97761		Prosthetic training
97762		C/o for orthotic/prosth use

Speech/Audiology Services

Procedure Code	Modifier	Brief Description
92506		Speech/hearing evaluation
92507		Speech/hearing therapy
92508		Speech/hearing therapy
92551		Pure tone hearing test, air
92630		Aud rehab pre-ling hear loss
92633		Aud rehab postling hear loss
97532		Cognitive skills development
97533		Sensory integration

Speech-Pathology Services (for speech-pathologists only)

Procedure Code	Modifier	Brief Description
92607		Ex for speech device rx, 1hr
92608		Ex for speech device rx addl
92609		Use of speech device service
92610		Evaluate swallowing function

Audiology Services (for audiologists only)

Procedure Code	Modifier	Brief Description
92552		Pure tone audiometry, air
92553		Audiometry, air & bone
92555		Speech threshold audiometry
92556		Speech audiometry, complete
92557		Comprehensive hearing test
92567		Tympanometry
92568		Acoustic refl threshold tst
92569		Acoustic reflex decay test

Audiology Services (for audiologists only) (cont.)

Procedure Code	Modifier	Brief Description
92579		Visual audiometry (vra)
92582		Conditioning play audiometry
92587	26	Evoked auditory test, professional component
92587	TC	Evoked auditory test, technical component
92588	26	Evoked auditory test, professional component
92588	TC	Evoked auditory test, technical component
92620		Auditory function, 60 min
92621		Auditory function, + 15 min

Psychology Services

Procedure Code	Modifier	Brief Description
96101		Psycho testing by psych/phys

Counseling Services

Procedure Code	Modifier	Brief Description
S9445		Pt education, NOC, individual
S9446		Pt education, NOC, group

Nursing Services

Procedure Code	Modifier	Brief Description
T1001		Nursing assessment/evaluatn
T1002*		RN services up to 15 minutes
T1003*		LPN/LVN services up to 15min

*** Use this code when billing for the following services:**

- Blood glucose testing and analysis
- Catheterization
- Chest wall manipulation/postural drainage
- Dressing/wound care
- Intravenous care/feedings
- Medication administration: oral, enteral, parenteral, inhaled, rectal, sub Q, IM
- Nebulizer treatment
- Nurse delegation (initiation and re-evaluation)
- Stoma care
- Testing oxygen saturation levels and adjusting oxygen levels
- Tracheotomy care/suctioning
- Tube feedings

Provider Qualification Updates

School medical services must be delivered by providers who meet federal and state requirements and who operate within the scope of his or her practitioner's license according to state law.

- **Physical therapy** – Physical therapy must be provided by a licensed physical therapist.

- **Occupational therapy** – Occupational therapy must be provided by a licensed occupational therapist or a certified occupational therapy assistant supervised by a licensed occupational therapist.

- **Speech-language therapy** –

  Speech-language therapy **must** be provided by:

  - ✓ A licensed speech-language pathologist; or

  - ✓ A school speech therapist who:

    - ➢ Meets the education and work experience necessary for a license;
    - ➢ Is certified by the Washington Professional Educator Standards Board as an educational staff associate; and
    - ➢ Limits practice to the school setting.

  Speech-language therapy **may** be provided by a certified speech pathology assistant who is supervised by a speech-language pathologist with a certificate of clinical competence (CCC).

- **Audiology services** – Audiology services must be provided by:

  - ✓ A licensed audiologist; or

  - ✓ A school audiologist who:

    - ➢ Meets the education and work experience necessary for a license;

    - ➢ Is certified by the Washington Professional Educator Standards Board as an educational staff associate; and

    - ➢ Limits practice to the school setting.

- **Psychology services** – Psychology services must be provided by:

  - ✓ A licensed psychologist; or
  - ✓ A person who holds a masters degree in school psychology and has a valid school psychologist credential from the Washington Professional Educator Standards Board.

- **Counseling services** – Counseling services must be provided by:

  - ✓ A licensed social worker or mental health counselor; or
  - ✓ A social worker or mental health counselor who:
    - ➢ Meets the education and work experience necessary for a license; and
    - ➢ Is certified by the Washington Professional Education Standards Board as an educational staff associate.

- **Nursing services –** Nursing services must be provided by:

  - ✓ A licensed registered nurse;
  - ✓ A licensed practical nurse; or
  - ✓ Non-credentialed school employees:
    - ➢ When delegated by a registered nurse; and
    - ➢ Only for certain limited healthcare tasks.

    The registered nurse and the non-credentialed school employee must comply with the delegation, training, and supervision requirements addressed in RCW 28A.210.260 and 28A.210.289.

Billing Instructions Replacement Pages

Attached are updated replacement pages i-ii, C.1-C.6, D.1-D.2, E.1-E.2, F.1-F.4, and G.1-G.2 for DSHS's current *School Medical Services Billing Instructions.*

How do I access WAMedWeb?

This is a resource for healthcare providers conducting business electronically with Washington State Medicaid. http://wamedweb.acs-inc.com.

How can I get DSHS's provider documents?

To obtain DSHS/HRSA provider numbered memoranda and billing instruction, go to the DSHS/HRSA website at http://hrsa.dshs.wa.gov (click ***the Billing Instructions and Numbered Memorandum*** link). These may be downloaded and printed.

Table of Contents

Covered Services and Procedures

Physical Therapy

Physical therapy evaluation and treatment services include the following:

- Assessing;
- Preventing; and
- Alleviating movement dysfunction and related functional problems.

Listed below are descriptions of covered physical therapy services with the corresponding billing codes.

Procedure Code	Modifier	Brief Description	Maximum Allowable Fee
97001	None	PT evaluation	Click here for current fee schedule: http://maa.dshs.wa.gov/RBRVS/Index.html
97002	None	PT reevaluation	
97110*	None	Therapeutic exercises	
97112	None	Neuromuscular reeducation	
97116	None	Gait training therapy	
97124	None	Massage therapy	
97139	None	Physical medicine procedure	
97150	None	Group therapeutic procedures	
97530	None	Therapeutic activities	
97535	None	Self care mngment training	
97537	None	Community/work reintegration	
97542	None	Wheelchair mngment training	
97750	None	Physical performance test	
97755	None	Assistive technology assess	
97760	None	Orthotic mgmt and training	
97761	None	Prosthetic training	
97762	None	C/o for orthotic/prosth use	

* Use CPT code 97110 to bill for fine or gross motor therapy.

Occupational Therapy

Occupational therapy evaluations and treatment services include the following:

- Assessing, improving, developing, or restoring functions impaired or lost through illness, injury, or deprivation;
- Improving ability to perform tasks for independent functioning when functions are lost or impaired; and
- Preventing initial or further impairment or loss of function through early intervention.

Listed below are descriptions of covered occupational therapy services with the corresponding billing codes.

Procedure Code	Modifier	Brief Description	Maximum Allowable Fee
95851	None	Range of motion measurements	Click here for current fee schedule: http://maa.dshs.wa.gov/RBRVS/Index.html
95852	None	Range of motion measurements	
97003	None	Ot evaluation	
97004	None	Ot re-evaluation	
97110	None	Therapeutic exercises	
97112	None	Neuromuscular reeducation	
97150	None	Group therapeutic procedures	
97530	None	Therapeutic activities	
97532	None	Cognitive skills development	
97533	None	Sensory integration	
97535	None	Self care mngment training	
97537	None	Community/work reintegration	
97542	None	Wheelchair mngment training	
97750	None	Physical performance test	
97755	None	Assistive technology assess	
97760	None	Orthotic mgmt and training	
97761	None	Prosthetic training	
97762	None	C/o for orthotic/prosth use	

Speech-Language Therapy

Speech-language therapy evaluations and treatment services include the following:

- Assessment of speech and/or language disorders;
- Diagnosis and appraisal of specific speech and/or language disorders;
- Provision of speech or language services for the prevention of communicative disorders; and
- Referral for medical and other professional attention necessary for the rehabilitation of speech and/or language disorders.

The following services may be billed only by a speech-language pathologist:

Procedure Code	Modifier	Brief Description	Maximum Allowable Fee
92607	None	Ex for speech device rx, 1hr	Click here for current fee schedule: http://maa.dshs.wa.gov/RBRVS/Index.html
92608	None	Ex for speech device rx addl	
92609	None	Use of speech device service	
92610	None	Evaluate swallowing function	

The following services may be billed by both a speech pathologist and an audiologist:

Procedure Code	Modifier	Brief Description	Maximum Allowable Fee
92506	None	Speech/hearing evaluation	Click here for current fee schedule: http://maa.dshs.wa.gov/RBRVS/Index.html
92507	None	Speech/hearing therapy	
92508	None	Speech/hearing therapy	
92551	None	Pure tone hearing test, air	
92630	None	Aud rehab pre-ling hear loss	
92633	None	Aud rehab postling hear loss	
97532	None	Cognitive skills development	
97533	None	Sensory integration	

Audiology

Audiology evaluation and treatment services include the following:

- Assessment of hearing loss;
- Determination of the range, nature, and degree of hearing loss, including the referral for medical or other professional attention for restoration or rehabilitation due to hearing disorders; and
- Provision of rehabilitative activities, such as speech restoration or rehabilitation, auditory training, hearing evaluation and speech conversation, and determination of the need for individual amplification.

The following services may be billed only by an audiologist:

Procedure Code	Modifier	Brief Description	Maximum Allowable Fee
92552	None	Pure tone audiometry, air	Click here for current fee schedule: http://maa.dshs.wa.gov/RBRVS/Index.html
92553	None	Audiometry, air & bone	
92555	None	Speech threshold audiometry	
92556	None	Speech audiometry, complete	
92557	None	Comprehensive hearing test	
92567	None	Tympanometry	
92568	None	Acoustic refl threshold tst	
92569	None	Acoustic reflex decay test	
92579	None	Visual audiometry (vra)	
92582	None	Conditioning play audiometry	
92587	26	Evoked auditory test, professional component	
92587	TC	Evoked auditory test, technical component	
92588	26	Evoked auditory test, professional component	
92588	TC	Evoked auditory test, technical component	
92620	None	Auditory function, 60 min	
92621	None	Auditory function, + 15 min	

Nurse Services

Nursing assessment and treatment services include:

- Medical and remedial services ordered by a physician or other licensed practitioner within his/her scope of practice; and

- Assessments, treatment services, and supervision of delegated health care services provided to:

  ✓ Prevent disease, disability, or the progression of other health conditions;
  ✓ Prolong life; and
  ✓ Promote physical and mental health and efficiency.

Listed below are descriptions of covered nursing services with the corresponding billing codes.

Procedure Code	Modifier	Brief Description	Maximum Allowable Fee
T1001	None	Nursing assessment/evaluatn	Click here for current fee schedule: http://maa.dshs.wa.gov/RBRVS/Index.html
T1002*	None	RN services up to 15 minutes	
T1003*	None	LPN/LVN services up to 15min	

*** Use this code when billing for the following services:**

- Blood glucose testing and analysis
- Catheterization
- Chest wall manipulation/postural drainage
- Dressing/wound care
- Intravenous care/feedings
- Medication administration: oral, enteral, parenteral, inhaled, rectal, sub Q, IM
- Nebulizer treatment
- Nurse delegation (initiation and re-evaluation)
- Stoma care
- Testing oxygen saturation levels and adjusting oxygen levels
- Tracheotomy care/suctioning
- Tube feedings

Psychological Assessments

Psychological services include the following:

- Psychological and developmental testing; and
- Interpreting test results and preparing reports.

Listed below is the description of the covered psychological service with the corresponding billing code.

Procedure Code	Modifier	Brief Description	Maximum Allowable Fee
96101	None	Psycho testing by psych/phys	Click here for current fee schedule: http://maa.dshs.wa.gov/RBRVS/Index.html

Counseling Services

Counseling services include therapeutic intervention services to assist a person with the adjustment to their disabling condition.

Listed below are the descriptions of covered counseling services with the corresponding billing codes.

Procedure Code	Modifier	Brief Description	Maximum Allowable Fee
S9445	None	Pt education, NOC, individual	Click here for current fee schedule: http://maa.dshs.wa.gov/RBRVS/Index.html
S9446	None	Pt education, NOC, group	

Provider Requirements

School medical services must be delivered by providers who meet federal and state requirements and who operate within the scope of his or her practitioner's license according to state law.

- **Physical therapy** – Physical therapy must be provided by a licensed physical therapist.

- **Occupational therapy** – Occupational therapy must be provided by a licensed occupational therapist or a certified occupational therapy assistant supervised by a licensed occupational therapist.

- **Speech-language therapy** –

  Speech-language therapy must be provided by:

  - ✓ A licensed speech-language pathologist; or
  - ✓ A school speech therapist who:
    - ➢ Meets the education and work experience necessary for a license;
    - ➢ Is certified by the Washington Professional Educator Standards Board as an educational staff associate; and
    - ➢ Limits practice to the school setting.

  Speech-language therapy **may** be provided by a certified speech pathology assistant who is supervised by a speech-language pathologist with a certificate of clinical competence (CCC).

- **Audiology services** – Audiology services must be provided by:

  - ✓ A licensed audiologist; or
  - ✓ A school audiologist who:
    - ➢ Meets the education and work experience necessary for a license;
    - ➢ Is certified by the Washington Professional Educator Standards Board as an educational staff associate; and
    - ➢ Limits practice to the school setting.

- **Psychology services** – Psychology services must be provided by:

  - ✓ A licensed psychologist; or

  - ✓ A person who holds a masters degree in school psychology and has a valid school psychologist credential from the Washington Professional Educator Standards Board and who limits practice to the school setting.

- **Counseling services** – Counseling services must be provided by:

  - ✓ A licensed social worker or mental health counselor; or

  - ✓ A social worker or mental health counselor who:

    - ➢ Meets the education and work experience necessary for a license; and
    - ➢ Is certified by the Washington Professional Education Standards Board as an educational staff associate.

- **Nursing services –** Nursing services must be provided by:

  - ✓ A licensed registered nurse;

  - ✓ A licensed practical nurse; or

  - ✓ Non-credentialed school employees:

    - ➢ When delegated by a registered nurse; and
    - ➢ Only for certain limited healthcare tasks.

    The registered nurse and the non-credentialed school employee must comply with the delegation, training, and supervision requirements addressed in RCW 28A.210.260 and 28A.210.289.

Payment

What does HRSA pay school districts for?

HRSA pays school districts for:

- Direct services; and
- Evaluations that result in the determination that a student is a child with a disability and is in need of special education and related services; or
- Re-evaluations to determine whether the student continues to be in need of special education and related services.

> **Note:** A unit of service is based upon the CPT and HCPCS code description. For any code that is reimbursed based upon time each measure of time as defined by the code equals on unit. If the code description does not include time, the service itself that is described by the code equals one unit regardless of how time spent.

Fee Schedule

You may view HRSA's **School Medical Services Fee Schedule** on-line at

http://maa.dshs.wa.gov/RBRVS/Index.html

For a paper copy of the fee schedule:

- **Go to:** http://www.prt.wa.gov (On-line orders filled daily.) Click **General Store**. Follow prompts to **Store Lobby → Search by Agency → Department of Social and Health Services → Health and Recovery Services Administration →** desired document; **or**
- **Fax/Call:** Dept. of Printing/Attn: Fulfillment at FAX 360.586.6361/ telephone 360.586.6360. (Telephoned or faxed orders may take up to 2 weeks to fill.)

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Billing

What is the time limit for billing? [Refer to WAC 388-502-0150]

HRSA has two timeliness standards for: 1) initial claims; and 2) resubmitted claims.

- **Initial Claims**

  ✓ HRSA requires providers to obtain an ICN for an **initial claim** within 365 days from any of the following:

  - The date the provider furnishes the service to the eligible client;
  - The date a final fair hearing decision is entered that impacts the particular claim;
  - The date a court orders HRSA to cover the services; or
  - The date DSHS certifies a client eligible under delayed[1] certification criteria.

  ✓ HRSA may grant exceptions to the 365 day time limit for **initial claims** when billing delays are caused by either of the following:

  - DSHS certification of a client for a retroactive[2] period; or
  - The provider proves to HRSA's satisfaction that there are extenuating circumstances.

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[1] **Delayed Certification -** According to WAC 388-500-0005, delayed certification means department approval of a person's eligibility for a covered service made after the established application processing time limits. If, due to delayed certification, the client becomes eligible for a covered service that has already been provided, **the provider must not bill**, demand, collect, or accept payment from the client or anyone on the client's behalf for the service; and **must promptly refund** the total payment received from the client or anyone acting on the client's behalf and then bill HRSA for the service.

Eligibility Established After Date of Service but Within the Same Month - If the client becomes eligible for a covered service that has already been provided because the client applied to the department for medical services later in the same month the service was provided (and is made eligible from the first day of the month), **the provider must not bill**, demand, collect, or accept payment from the client or anyone acting on the client's behalf for the service; and **must promptly refund** the total payment received from the client or anyone acting on the client's behalf and then bill HRSA for the service.

[2] **Retroactive Certification -** According to WAC 388-500-0005, retroactive period means the three calendar months before the month of application (month in which client applied). If, due to retroactive certification, the client becomes eligible for a covered service that has already been provided, **the provider must not bill**, demand, collect, or accept payment from the client or anyone acting on the client's behalf for any unpaid charges for the service; **and may refund** any payment already received from the client or anyone acting on the client's behalf, and after refunding the payment, the provider may bill HRSA for the service.

- **Resubmitted Claims**

  Providers may **resubmit, modify, or adjust** any timely initial claim, **except** prescription drug claims, for a period of 36 months from the date of service. Prescription drug claims must be resubmitted, modified, or adjusted within 15 months from the date of service.

  Note: HRSA does not accept any claim for resubmission, modification, or adjustment after the time period listed above.

- The time periods do not apply to overpayments that the provider must refund to DSHS. After the allotted time periods, a provider may not refund overpayments to HRSA by claim adjustment. The provider must refund overpayments to HRSA by a negotiable financial instrument such as a bank check.

- The provider, or any agent of the provider, must not bill a client or a client's estate when:

  ✓ The provider fails to meet these listed requirements; and
  ✓ HRSA does not pay the claim.

What fee should I bill HRSA for eligible clients?

Bill HRSA your usual and customary fee.

When can I bill the client?

Please refer to HRSA's *General Information Booklet* for information on billing the client or to WAC 388-502-0160.

How do I bill for services provided to Primary Care Case Management (PCCM) clients?

When billing for services provided to PCCM clients:

- Enter the referring physician or Primary Care Case Manager name in field 17 on the 1500 claim form; and

- Enter the HRSA seven-digit identification number of the Primary Care Case Managers (PCCM) who referred the client for the service(s). If the client is enrolled in a PCCM plan and the PCCM referral number is **not** in field 17a when you bill HRSA, the claim will be denied.

Third-Party Liability

Note: Districts may choose not to bill HRSA for special education students who have other third-party insurance

OSPI provides school districts with third-party insurance coverage information for special education students. The district may choose not to bill HRSA for services provided to children who have third-party insurance. School districts are *not* required to pursue third-party reimbursement when HRSA is not being billed. If a district chooses to bill HRSA for students with third-party insurance coverage, the district must:

- Bill these carriers **before** billing HRSA; and

- Request, in writing, consent from the student's parent(s)/guardian(s) to bill the student's insurance carrier before billing the carrier. This letter should clearly state the conditions and consequences of this billing program as referenced in RCW 74.09.5249.

When HRSA is being billed:

- If the insurance reimbursement amount is *less than the HRSA maximum allowance*, or the charges are denied by an insurance company, you should rebill the claim to HRSA. You will need to attach a copy of the insurance company's Eligibility of Benefits (EOB) when you rebill.

- If you bill HRSA because the third party paid less than the HRSA allowed amount, and HRSA *denies the service*, you must accept the third-party payment as payment in full.

You must bill the insurance carrier(s) indicated on the client's Medical ID card. An insurance carrier's time limit for claim submissions may be different from HRSA's. It is your responsibility to meet the insurance carrier's requirements relating to billing time limits, as well as HRSA's, prior to any payment by HRSA.

You must meet HRSA's 365-day billing time limit even if you haven't received notification of action from the insurance carrier. If your claim is denied due to any existing third-party liability, refer to the corresponding HRSA Remittance and Status Report for insurance information appropriate for the date of service.

If you receive an insurance payment and the carrier pays you less than the maximum amount allowed by HRSA, or if you have reason to believe that HRSA may make an additional payment:

- Submit a completed claim form to HRSA;
- Attach the insurance carrier's statement or EOB;

- If rebilling, also attach a copy of the HRSA Remittance and Status Report showing the previous denial; or
- If you are rebilling electronically, list the claim number (ICN) of the previous denial in the comments field of the Electronic Media Claim (EMC).

Third-party carrier codes are available on HRSA's website at http://maa.dshs.wa.gov or by calling the Coordination of Benefits at 800.562.6136.

What records must be kept? [Refer to WAC 388-502-0020]

Enrolled providers must:

- Keep legible, accurate, and complete charts and records to justify the services provided to each client, including, but not limited to:

  - ✓ Patient's name and date of birth;
  - ✓ Dates of service(s);
  - ✓ Name and title of person performing the service, if other than the billing practitioner;
  - ✓ Chief complaint or reason for each visit;
  - ✓ Pertinent medical history;
  - ✓ Pertinent findings on examination;
  - ✓ Medications (including NDC numbers), equipment, and/or supplies prescribed or provided;
  - ✓ Description of treatment (when applicable);
  - ✓ Recommendations for additional treatments, procedures, or consultations;
  - ✓ X-rays, tests, and results;
  - ✓ Plan of treatment and/or care, and outcome; and
  - ✓ Specific claims and payments received for services.

- Assure charts are authenticated by the person who gave the order, provided the care, or performed the observation, examination, assessment, treatment or other service to which the entry pertains.

- Make charts and records available to DSHS, its contractors, and the US Department of Health and Human Services, upon their request, **for at least six years from the date of service** or more if required by federal or state law or regulation.

A provider may contact HRSA with questions regarding HRSA's programs. However, HRSA's response is based solely on the information provided to HRSA's representative at the time of inquiry, and in no way exempts a provider from following the laws and rules that govern HRSA's programs. (Refer to WAC 388-502-0020[2])

[3] WAC 388-502-0020, filed 8/00, sets a six-year record retention requirement for all HRSA providers. The WAC establishes a time frame for records that is significantly longer than the direction previously given to school districts. HRSA expects school districts to move toward compliance and retain records for the longer period of time.

Completing the 1500 Claim Form

Attention! HRSA now accepts the new 1500 Claim Form.

- **On November 1, 2006,** HRSA began accepting the new 1500 Claim Form (version 08/05).
- **As of April 1, 2007**, HRSA will no longer accept the old HCFA-1500 Claim Form.

Note: HRSA encourages providers to make use of electronic billing options. For information about electronic billing, refer to the *Important Contacts* sections.

Refer to HRSA's current *General Information Booklet* for instructions on completing the 1500 claim form. You may download this booklet from HRSA's website at: http://maa.dshs.wa.gov/download/Billing%20Instructions%20Web%20Pages/General%20Information.html or request a paper copy from the Department of Printing (see Important Contacts section).

The following 1500 claim form instructions relate to **School Based Medical Services Billing Instructions**. Click the link above to view general 1500 Claim Form instructions.

For questions regarding claims information, call HRSA toll-free:

800.562.3022

Field No.	Name	Field Required	Entry
17.	**Name of Referring Physician or Other Source**	**No - Optional**	Enter the referring physician for physical therapy and occupational therapy sessions.
24A.	**Date(s) of Service**	**Yes**	For each procedure code being billed, enter the first day of the month for which you are billing in the *From* section. Enter the last day of that month in the *To* section. This allows all charges during one month for one procedure code to be billed on one line. **When billing multiple months of service, use a separate line for each month.** Enter dates numerically (e.g., October 1, 2003 = 100103). Do not use slashes, dashes or hyphens to separate month, day, year - MMDDYY.

Field No.	Name	Field Required	Entry
24B.	**Place of Service**	**Yes**	**On and after October 1, 2003, use the following Place of Service codes:** 03 School 12 Student's residence
24C.	**Type of Service**	**No**	**For claims with dates of service on and after October 1, 2003, this field IS NOT A REQUIRED FIELD.**
24E.	**Diagnosis Code**	**Yes**	**Enter V41.9**, unspecified problem with special functions.
24F.	**$ Charges**:	**Yes**	Enter your usual and customary charge for the service performed. If more than one unit is being billed, the charge shown must be for the total of the units billed. Do not include dollar signs or decimals in this field. Do not add sales tax. Sales tax is automatically calculated by the system and included with your remittance amount.
24G.	**Days or Units**	**Yes**	For each procedure code, enter the total number of billable units.